MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

03671 96

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Agnes Jackson Atkinson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George A. Atkinson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	30	hrs. min.

9. Birthplace: Perryville, Cecil Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Samuel Jackson

13. Birthplace: Cecil County

MOTHER 14. Maiden name: Mary Agnes Richardson

15. Birthplace: Cecil County

16. Informant: George A. Atkinson

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-13-46 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: Port Deposit, Rural, Md.

18. Funeral director: Lee A. Patterson & Son

Address: Box 157, Perryville, Md.

19. Filed 4-13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April - 10 1946, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 18 1945 to Apr 10 - 1946 and that I last saw her alive on April 10 - 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage (Paralysis Right side) -	6 Months.
Due to: Arterio - Sclerosis	10 yrs.
Hypertension -	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Johnson, M. D. M. D. or other

Address: Port Deposit Date signed 4-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

03672

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Helen Edna Boatzman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 1 1929

8. AGE:

Years	Months	Days	If less than one day
17	4	15	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Homemaker
11. Industry or business:

FATHER
12. Name: Francis Boatzman
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice Schofield
15. Birthplace: Pennsylvania

16. Informant: Frank Boatzman
Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 18 '46 (month) (day) (year)
Cemetery or crematory: Mt Zion Church
Location: Fairfield, Pa

18. Funeral director: H.W. Pippin
Address: Elkton, Md.

19. Apr 17 1946 (Date rec'd by registrar) J R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gastric Hemorrhage	
Due to Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 4-16-46
Where did injury occur? Elkton (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Injured at work?

23. SIGNATURE: R. L. Dodson M.D.
M. D. or other
Address: Elkton Md. Date signed 4/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

03673

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred: Union Hospital Elkton Md
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rising Sun Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Body

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col	Widower

6.(b) Name of husband or wife: Mamie Body.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 19. 1863

8. AGE: Years 83 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Cecil Co Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Moses Jones
13. Birthplace: Conowingo, Md.

MOTHER
14. Maiden name: Charlott Body
15. Birthplace: Conowingo, Md.

16. Informant: Helen Body
Address: Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 22 46 (month) (day) (year)
Cemetery or crematory: Mt Joy
Location: Conowingo Md.

18. Funeral director: J E Lupton
Address: Rising Sun Md.

19. April 21 1946 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946, at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1946, to April 18 1946
and that I last saw h... alive on April 18 1946

	DURATION
Immediate cause of death: Intestinal obstruction	
Due to: Rectosigmoid lesion — partially carcinoma.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Colostomy — April 3, 1946
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald H. Sprague M. D. or other
Address: Elkton, Md. Date signed April 19

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

03674

CERTIFICATE OF DEATH

★ Reg. Dist. No. 91

1. PLACE OF DEATH:

County Cecil

City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Cecil

City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war not a Veteran

3.(a) FULL NAME William M. Brown

3.(b) Social Security Number 213-01-9063

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Anna Agars Brown

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 17 — 1875

8. AGE: Years 71 | Months — | Days 2 | If less than one day ..... hrs. ..... min. 1875

9. Birthplace Salem N. J.
(Town, county, and state)

10. Usual occupation Lumber Dealer

11. Industry or business Retired 1 year

FATHER 12. Name William M. Brown

13. Birthplace New Jersey

MOTHER 14. Maiden name Waddington

15. Birthplace New Jersey

16. Informant Mrs Joseph Schaefer

Address Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-21-46 (month) (day) (year)

Cemetery or crematory Bethel

Location Chesapeake City Rural Md

18. Funeral director Joseph A. Shaefer

Address North East Md

19. April 20 1946 (Date rec'd by registrar) Mrs Ralph D. Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946, at 6 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1942 to April 19 1946

and that I last saw h... alive on April 19 1946

Immediate cause of death	DURATION
Embolism of lungs	2 days
Due to Chronic Nephritis	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas N. Davis M.D.
M. D. or other

Address Chesapeake City Md Date signed 4/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03675

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: East Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: East Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Grarry
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Angelo Cifaldo

3.(b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Angelina Cifaldo
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1886

8. AGE: Years: 60 | Months: 2 | Days: 13. | If less than one day: hrs. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Stone Quary

FATHER
12. Name: Domenic Cifaldo
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Italy

16. Informant: Domenic Cifaldo
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23 1946 (month) (day) (year)
Cemetery or crematory: Brookview
Location: Rising Sun, Md
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. April 22 19 46 Irma E. Dunford
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 19 46 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. LeRoy Dodson M.D.
M. D. or other
Address: Rising Sun Md. Date signed: April 26 46

Chief Medical Examiner Cecil County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

CERTIFICATE OF DEATH

63676

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Rural / Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rising Sun (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Between Farmington & Calvert

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ann Dora Conner

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Oliver W. Conner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1873

8. AGE:	Years	Months	Days	If less than one day
	72	5	6	..... hrs. ..... min.

9. Birthplace Glamsdam Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name Henry Lewis

13. Birthplace Penn.

MOTHER

14. Maiden name Sara Fry

15. Birthplace Penn

16. Informant Mrs Martha Rogers

Address Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1946 (month) (day) (year)

Cemetery or crematory Friends

Location Calvert, Md.

18. Funeral director Ralph M Reed

Address Rising Sun, Md.

19. Apr 26 1946 L M Worthington (Date rec'd by registrar) Registrar

Permit issued Apr 26-46

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946 at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946 to April 23 1946

and that I last saw her alive on 4/23 1946

Immediate cause of death	DURATION
Carcinoma of Pancreas	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R E Dodson MD M. D. or other

Address Rising Sun Md Date signed 4/25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03677 ★ Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Cecil

City or town: North East, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachel Ann Ferguson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Ferguson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 12 1867

8. AGE:

Years	Months	Days	If less than one day
78	8	7	..... hrs. ..... min.

9. Birthplace: North East R. D. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Thos. B. McKinney

13. Birthplace: Md

MOTHER 14. Maiden name: Elizabeth Mahoney

15. Birthplace: Md

16. Informant: Andrew Ferguson

Address: North East Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 23 1946 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R. Grace

Address: North East Md.

19. 4/23 1946 (Date rec'd by registrar) Lead E. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946 at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr-19 1946 to Apr-19 1946 and that I last saw h[illegible] alive on Apr-19 1946

Immediate cause of death	DURATION
Coronary occlusion	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. B. Collins M. D. or other

Address: North East, Md. Date signed: 4-22-46

03678

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

Reg. Dist. No. 9L

1. PLACE OF DEATH:
County: Cecil
City or town: Cecilton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Cecilton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Lawrence Fields

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col	Single

6.(b) Name of husband or wife
6.(c) If elive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 1 1946

8. AGE: Years | Months: 4 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Wilmington Gen Hosp Del.
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER
12. Name: John Smith
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Laura Fields
15. Birthplace: Cecil Co Md.

16. Informant: Laura Fields
Address: Middletown Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25 1946 (month) (day) (year)
Cemetery or crematory Odd Fellows, Middletown Del.
Location

18. Funeral director: Custis O. Caulk
Address: 827 Pine St. Wilm. Del.

19. April 24 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1946, at 2 p. m.

21. I CERTIFY that death occurred on the date above stated, and that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death: Smothered — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 4-22-46
Where did injury occur? Cecilton Rural Cecil Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Manner of injury: Smothered in bed Injured at work?

23. SIGNATURE: R L Dodson MD
Address: Rural Route 1 Date signed: 4-22-46
M. D. or other

Medical Examiner
County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

03679

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland, Veterans Administration Center

(If outside city or town limits, write RURAL and give nearest town).

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2228 Calvert Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: FURLONG, Raymond B.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Grace M. Furlong

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 8-18-97

8. AGE: Years	Months	Days	If less than one day
48	7	22	— hrs. — min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Banker

11. Industry or business: —

FATHER 12. Name: Phillip J. Furlong

13. Birthplace: Maryland

MOTHER 14. Maiden name: Anne Coffey

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-9-46 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: St. Mary's, Pa.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Apr. 9 19 46 (Date rec'd by registrar) Irene Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 19 46, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 46, to April 9 19 46 and that I last saw him alive on April 9 19 1946

Immediate cause of death	DURATION
Myocardial Degeneration	Unknown
Due to: Coronary Arteriosclerosis	Unknown
Due to: Pleurisy, with effusion	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, M.D., Clinical Director Acting for the Manager, Veterans Administration, Perry Point, Md. M.D. or other

Address: Date signed 4-9-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 03680 Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Mth East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Julio G Gonzalog.

3.(b) Social Security Number: 058-22-1780

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Mexic	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): —

8. AGE: Years	Months	Days	If less than one day
40 ?			hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: no information
11. Industry or business:

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Henry Harvey
Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16-46 (month) (day) (year)
Cemetery or crematory: County
Location: Cherry Hill Md
18. Funeral director: Joseph A Chaun
Address: North East Md

19. 4/16 1946 (Date rec'd by registrar) Lida V. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1946 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Coronary	
Due to: Thrombosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. L. Dodson MD Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed 4-15-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03681 42

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Cecil

City or town: Rural Elkton RD 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, Institution, or street address where death occurred: Elkton RD 4

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Rural Near Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RD 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Gross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 7, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	28	..... hrs. ..... min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Thomas B. Gross

13. Birthplace: Pa

MOTHER — 14. Maiden name: Elizabeth Hand

15. Birthplace: Delaware

16. Informant: Emma Rebecca Gross

Address: Elkton RD 4, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 9/46 (month) (day) (year)

Cemetery or crematory: Union

Location: Elkton RD 4, Md

18. Funeral director: H W Peppin

Address: Elkton, Md

19. April 9 1946 (Date rec'd by registrar) H F Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1946, at 10 00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 28 1944, to April 5 1946 and that I last saw h.. alive on April 5 1946

Immediate cause of death	DURATION
Cardio-vascular-renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas Ford H. Spreaker, M. D. M. D. or other

Address: Elkton, Md Date signed: April 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

03682 42

Reg. Diat. No.

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hospital, Elkton, Md.

How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Helen J. Heisler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph M Heisler

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct 15 1884

8. AGE:

Years	Months	Days	If less than one day
61	5	16	..... hrs. ..... min.

9. Birthplace: North East Cecil Co Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William C Clark

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Helen Murdock

15. Birthplace: Maryland

16. Informant: Joseph R Grant

Address: North East. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 4 1946 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R. Grant

Address: North East Md.

19. Apr 4 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946, at 8.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1946 to April 1, 1946

and that I last saw her alive on April 1, 1946

Immediate cause of death	DURATION
Cardiac Embolism	
Due to: Pancreatitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. A. Cundall M.D.

M. D. or other

Address: North East Md Date signed: Apr 3/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-B)

03683

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Cecil.
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred: E Main St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: E Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Evelyn C. Howard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 29, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	0	hrs. min.

9. Birthplace: Elkton
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business
FATHER 12. Name: W. H. M. Howard
13. Birthplace: Elkton, Md
MOTHER 14. Maiden name: Lavinia Foard
15. Birthplace: Elkton, Md
16. Informant: Morion R. McCarty
Address: 110 Bow St Elkton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2/46 (month) (day) (year)
Cemetery or crematory: Elkton Cem
Location: Elkton Md
18. Funeral director: H. W. Lippincott
Address: Elkton, Md
19. May 1 1946 (Date rec'd by registrar) I R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1946 to April 29 1946 and that I last saw her alive on April 29 1946

Immediate cause of death: Pleurisy caused by being chilled while riding in an automobile — DURATION: 7 days

Due to:

Due to:

Other conditions: Chronic cholecystitis. Cystitis
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Morrison, M. D.
M. D. or other
Address: Elkton, Md Date signed 4-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-d)

CERTIFICATE OF DEATH

03684

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Conowingo Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Conowingo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Washington Kennard — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Catherine Kennard
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 12 1867

8. AGE: Years 88 | Months 9 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Harford Co Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Jacob Kennard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Garrett
15. Birthplace: Cecil Co Md

16. Informant: Catherine Kennard
Address: Conowingo Md

17. Burial (Burial, cremation, removal. Which?) Date thereof April 7 1946 (month) (day) (year)
Cemetery or crematory: Mt Pleasant
Location: Colora Md.

18. Funeral director: J. C. Tyson
Address: Rising Sun Md

19. Apr 6 1946 (Date rec'd by registrar) — Registrar

Permit issued Apr 6-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1946, at 4.20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Chronic Myocarditis	
Due to (b) Duration: Unknown. Coroner's P.M.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: W. H. Dolan M.D. Medical Examiner for Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 4/5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 84

03685

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH

County: CECIL

City or town: VETERANS ADMINISTRATION, PERRY POINT, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Kanowha County

City or town: Charleston
(If outside city or town limits, write RURAL and giva nearest town)

Street No.: 2226 Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II ✓

3.(a) FULL NAME: LILLY, David G. Jr.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 11-21-1908

8. AGE: Years: 37 | Months: 5 | Days: 4 | If less than one day: — hrs. — min.

9. Birthplace: Charleston, W. Va.
(Town, county, and state)

10. Usual occupation: Attorney

11. Industry or business: —

FATHER
12. Name: David Green Lilly
13. Birthplace: Summers County, W. Va.

MOTHER
14. Maiden name: Nellie McGinnis
15. Birthplace: Raleigh County, W. Va.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-25-46 (month) (day) (year)

Cemetery or crematory: Sunset Memorial Cemetery

Location: Kanowha County, Charleston, W. Va.

18. Funeral director: Pennington & Son,
Address: Havre de Grace, Md.

19. April 25 1946 (Date rec'd by registrar) Irma E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1946, at 6:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1946, to April 25, 1946, and that I last saw him alive on April 25, 1946

	DURATION
Immediate cause of death: Malnutrition and exhaustion	over 1 mo.
Due to: Manic Depressive Psychosis, Manic Type	over 1 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatinns: —

Date of op.: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause tn which death shnnld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: H. G. Clarke M. D. or other

Address: G. CLARKE, M.D., Manager, Veterans Administration, Perry Point, Md. Date signed: 4-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

03686

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Conowingo Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Conowingo. R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Laura Mae Law

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 17 185-

8. AGE:

Years	Months	Days	If less than one day
93	5	13	hrs. min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: George Hugg
13. Birthplace: Unknown

MOTHER
14. Maiden name: Anna May Culley
15. Birthplace: Unknown

16. Informant: Robert McCullough
Address: Conowingo. Md. R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 1946 (month) (day) (year)
Cemetery or crematory: Pleasant Grove Pa.
Location: Pleasant Grove, Pa.

18. Funeral director: J. Edd Tyson
Address: Rising Sun, Md.

19. Apr 30 1946 (Date rec'd by registrar) L. M. Worthington Registrar
4-30-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~was~~ on April 28 1946, to 19; and that I last saw h~~er~~ alive on April 28 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John Oxelon M. D.
M. D. or other
Address: New Providence Date signed: 4/30/46

Permit

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03687

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Delaware

City or town: Marcus Hook
(If outside city or town limits, write RURAL and give nearest town)

Street No. Shady Hill Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dr. John Scott Miller Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Frances M. Miller

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): June 23 1906

8. AGE: Years: 39 Months: ~~3~~ Days: 25 If less than one day: hrs. min.

9. Birthplace: Chester, Pa.
(Town, county, and state)

10. Usual occupation: Medical Doctor

11. Industry or business

FATHER — 12. Name: John Scott Miller Sr.

FATHER — 13. Birthplace: Chester Pa.

MOTHER — 14. Maiden name: Bertha B Patten

MOTHER — 15. Birthplace: Chester Pa.

16. Informant: Mrs Bertha Miller

Address: Wallingford, Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 17 1946 (month) (day) (year)

Cemetery or crematory

Location: Chester, Pa.

18. Funeral director: H. W. Pippin & Son

Address: Elkton, Md. per W. C. Lusby

19. Apr 17 1946 (Date rec'd by registrar) I R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1946, at 5:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Fracture of Base of Skull.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 4-17-46

Where did injury occur? Elkton ave. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Field

Means of injury: Airplane Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md. Date signed: 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 13688 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Leeonards (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William M. Morrison
3.(b) Social Security Number: 216-01-7729

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Marion Angell Morrison
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 27, 1895
8. AGE: Years: 50 Months: 8 Days: 12 If less than one day: hrs. min.
9. Birthplace: Colora, Cecil co. Md (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business: Susquehanna Electric Co.
FATHER 12. Name: Granville Morrison
13. Birthplace: Cecil Co Md
MOTHER 14. Maiden name: Julia Simmers
15. Birthplace: Cecil Co., Md.
16. Informant: Marion A. Morrison
Address: Colora, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11, 1946 (month) (day) (year)
Cemetery or crematory: Westnottingham
Location: Colora, Md.
18. Funeral director: Wm A. Patterson & Son
Address: Perryville, Md.
19. April 11 1946 Irene E. Dungan Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1946 at 10a M
I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Coronary	
Due to: Thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 4-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

03689

★ Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Rural Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Cecil County Jail
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1863

8. AGE: Years 82 | Months | Days | If less than one day: hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Joseph Murray
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Donally
15. Birthplace Ireland

16. Informant Mrs Ellen Murray
Address 154 W. Main St Port Deposit

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 27/46 (month) (day) (year)
Cemetery or crematory Mt Ernin Catholic
Location Havre de Grace

18. Funeral director H.W Lippin
Address Elkton, Md

19. Apr 26 1946 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R L Dodson MD
Address Rising Sun Md Date signed 4-26-46 M. D. or other

Medical Examiner for Cecil County

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03690

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 20 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital, NTC, Bainbridge, Md.
How long in hospital or institution? 1 month 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Troy
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Hutton St., Troy, N. Y.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PICCIRILLO, Anthony Dominick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-25-28

8. AGE: Years	Months	Days	If less than one day
18	2	19	hrs. min.

9. Birthplace: Troy, New York (Town, county, and state)
10. Usual occupation: USN
11. Industry or business:

FATHER
12. Name: John Piccirillo
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary Fuscop
15. Birthplace: Italy

16. Informant: Records Office, U.S.Naval Hosp.
Address: Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-16-46 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Troy, New York

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Maryland

19. April 16 1946 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 April 1946 at 1:01 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 February 1946 to 14 April 1946 and that I last saw him alive on 14 April 1946

Immediate cause of death	DURATION
Glomerulo-nephritis Acute	80 days.
Due to:	
Due to:	
Other conditions: Sub-acute bacterial endocarditis	60 days.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: confirmed above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry C. Oard HARRY C. OARD, CAPT. (MC) USNR
M. D. or other
Address: USNH, NTC, Bainbridge, Md. Date signed: 4-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence forthe change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILE No. 104 JUN - 6 1946

03691

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Chesapeake City (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: not a veteran

3.(a) FULL NAME: Richard Edward Reynolds

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Margaret

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 26 1868

8. AGE: Years: 78 | Months: 11 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: North East Cecil Co Md (Town, county, and state)

10. Usual occupation: Retired Ship Carpenter

11. Industry or business:

FATHER — 12. Name: Richard Reynolds
13. Birthplace: Md

MOTHER — 14. Maiden name: Martha Donohue
15. Birthplace: Md

16. Informant: Lee C Allen
Address: Chesapeake City Md

17. (Burial, cremation, or removal) Burial Date thereof (month) Apr (day) 20 (year) 46

Cemetery or crematory: Bethel
Location: Chesapeake City Rural

18. Funeral director: Joseph R. Frazer
Address: North East Md

19. April 20 1946 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/17 1946, at 7 1/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1940, to April 17 1946, and that I last saw him alive on April 16 1946

Immediate cause of death	DURATION
Hypertensive Cardio Vascular disease	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H V Davis MD M. D. or other
Address: Chesapeake City Md Date signed 4/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

03692

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 2 mo.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Maryland.

How long in hospital or institution? 2 years 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: TEAT, Ollie H.

3.(b) Social Security Number: 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mae Teat

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): August 2, 1892

8. AGE: Years	Months	Days	If less than one day
53	8	8	...m...hrs. ...m...min.

9. Birthplace: Bridgetown, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER
12. Name: Jim Teat
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mandie Thomas
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-11-1946 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Greensboro, Caroline County, Md.

16. Funeral director: Cemmyer & Son

Address: Havre de Grace, Md.

19. April 11 19 46 Irma E. Dunkle Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 19 46, at 12:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 19 44, to April 10 19 46 and that I last saw h... im alive on April 10 19 46

Immediate cause of death	DURATION
Syphilis of the Central Nervous System, tabo-paretic type	Over 4 yrs.
Due to	
Due to	
Other conditions: Psychosis with syphilis of the Central Nervous System, tabo-paretic type. (Include pregnancy within 3 months of death)	Over 4 yrs.

Major findings of operations: —

Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Trollinger, M.D.
A.E. TROLLINGER, M.D. Clinical Director
M. D. or other

Address: Acting for the Manager Date signed: 4-10-46
Veterans Administration, Perry Point, Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-E)

CERTIFICATE OF DEATH

03693

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County: -
City or town: Gill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: South Cross Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2.

3.(a) FULL NAME: TUTTLE, Philip Bates

3.(b) Social Security Number: 027-16-9122

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	S.

6.(b) Name of husband or wife:
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 27, 1924.

8. AGE: Years	Months	Days	If less than one day
21	6	8	hrs. min.

9. Birthplace: MASSACHUSETTS (Town, county, and state)
10. Usual occupation: U.S. NAVY.
11. Industry or business

FATHER
12. Name: Arthur Edmond Tuttle
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Tuttle
15. Birthplace: Unknown

16. Informant: Records Office, U.S.Naval Hosp
Address: Bainbridge, Maryland

17. Burial, Removal Date thereof April 7 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Riverside Cemetery
Location: Gill, Mass.

18. Funeral director: Lyle Patterson Patterson & Son
Address: Perryville, Md.

19. April 7 1946 Irene E. Daughaday Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 APRIL 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 APRIL, 1946 to Death 19
and that I last saw him alive on 5 April, 1946. 19

	DURATION
Immediate cause of death: Asphyxiation by respiratory obstruction of bronchi.	4-5-46
Due to: Fracture simple, left femur.	
Due to: Received in motorcycle-auto accident.	4-2-46
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op. 4-5-46
Autopsy results: Above findings At Autopsy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 4-2-46.
Where did injury occur? Rt. #1 -near Poplar grove, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): On highway.
Means of injury: Injured at work?

23. SIGNATURE: Charles F. Berg
Charles F. Berg, Comdr.(MC) USNR. M.D. or other
Address: Bainbridge, Md. Date signed: 4/6/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03694 Reg. Dist. No. 94

1. PLACE OF DEATH:
County Cecil
City or town North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war — not a Veteran

3.(a) FULL NAME William H Ulary

3.(b) Social Security Number 218-14-8669

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence Ulary
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 13 1876

8. AGE: Years 69 Months Days If less than one day ... hrs. ... min.

9. Birthplace North East Rural (Town, county, and state)
10. Usual occupation Stationary Engineer
11. Industry or business
FATHER 12. Name Charles Ulary
13. Birthplace ~~Sandy~~ Zetna
MOTHER 14. Maiden name Annie Wilson
15. Birthplace Md
18. Informant Florence Ulary
Address North East RD 2 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1946 (month) (day) (year)
Cemetery or crematory Methodist
Location North East Md
18. Funeral director Joseph R. Grant
Address North East Md
19. 4/29 1946 Lida D. Crouse (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946 at 1230 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Acute Leukemia	
Due to Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County
Address Rising Sun Md M. D. or other Date signed 4/27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 95 — 5695

1. PLACE OF DEATH:

County: Cecil County

City or town: Rising Sun, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland, County: Cecil Co.

City or town: Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Stewart McClelland Ward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily D Ward

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Feb 10 - 1883

8. AGE:

Years	Months	Days	If less than one day
63	2		...hrs. ...min.

9. Birthplace: Pittsburgh Pa (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business

FATHER — 12. Name: William H Ward

13. Birthplace: Pittsburgh

MOTHER — 14. Maiden name: Sara Stewart

15. Birthplace: Pittsburgh

16. Informant: Emily D Ward

Address: Rising Sun, Maryld.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 1946 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. Filed: Apr 29, 1946 — Registrar: L Worthington

ISSUED APR 29 - 46.

PERMIT

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946, at 7:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1945, to April 26 1946 and that I last saw h... alive on 4/26 1946

Immediate cause of death	DURATION
Uremia.	
Due to: Coronary Occlusion	
Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H E Dodson M.D. M. D. or other

Address: Rising Sun Md. Date signed: 4/27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03695 94 Reg. Dist. No.

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mos.
Hospital, institution, or street address where death occurred: Union Hospital Elkton - Md
How long in hospital or institution? one month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William T. Reaves

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Reaver
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1868

8. AGE: Years 78 | Months 2 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Pleasant Hill Cecil Co. Md
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: General

FATHER
12. Name: Wm R Weaver
13. Birthplace: Md

MOTHER
14. Maiden name: Annie E Peterson
15. Birthplace: Md

16. Informant: Agnes Weaver
Address: North East Rd 2 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30 1946 (month) (day) (year)
Cemetery or crematory: Elkton Rural Union
Location: Elkton Rural
18. Funeral director: Joseph R Frazer
Address: North East Md

19. 4/29 1946 (Date rec'd by registrar) Lida B. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 27 1946 to April 26 1946 and that I last saw h. alive on April 26 1946

Immediate cause of death	DURATION
General Arteriosclerosis	unknown
Due to: Cardio-vascular-renal complications	
Due to:	
Other conditions: Cerebral Paralysis of several years duration	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury (injured at work?)

23. SIGNATURE: T. H. McLaughlin M. D. or other
Address: Elkton - Md Date signed: 4-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63697

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: not a Veteran

3.(a) FULL NAME: Adam Wiles

3.(b) Social Security Number: 245-07-5228

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Clara Lee Wiles
6.(c) If alive, give age: 27 years
7. Birth date of deceased (mo., day, yr.): July 8 1913

8. AGE: Years: 32 Months: Days: If less than one day: hrs. min.

9. Birthplace: Offen, Wilkes Co N. C. (Town, county, and state)
10. Usual occupation: Auto mechanic
11. Industry or business

FATHER
12. Name: Wilburn Wiles
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Martha Jane Prevette
15. Birthplace: North Carolina

16. Informant: Mrs Adam Wiles
Address: North East, Md RD

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 9 1946 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: North Wilkesboro, N.C.
18. Funeral director: Joseph R Grant
Address: North East, Md
19. Apr 9 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1946 at 1230 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Compound Fract of Skull, Fracture of Rt femur & multiple lacerations	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 4-6-46
Where did injury occur: North East (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route 7
Means of injury: Automobile Injured at work?

23. SIGNATURE: R L Dodson M.D. Medical Examiner M. D. or other
Address: Elkton Md Date signed: 4-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

13698

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Jane Woods.

3.(b) Social Security Number:

4. Sex: F.
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: William Woods.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 25, 1854
8. AGE: Years: 91 Months: Days: If less than one day: hrs. min.
9. Birthplace: Port Deposit, Cecil Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Wm. Archibald
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary A. Cutter
15. Birthplace: Cecil Co. Md.

16. Informant: Walter W. Reynolds
Address: Port Deposit Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 24, 1946. (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora, Md., Rural

18. Funeral director: Lewis A. Catterson & Son
Address: Perryville, Md.

19. April 22 19 46 Irma E. Douglass (Registrar)
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1946 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to April 21 1946 and that I last saw h.. alive on April 18 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	3 da
Due to: General Atheroma	20 yrs
Due to: Accidental fall—fell on ice, in yard. Cyst R.	
Other conditions: Ununited Intra capsular fracture of femur	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: February 14th 1946.
Where did injury occur? Port Deposit. (City or town) Cecil. (County) Maryland. (State)
Injured at home, farm, industry, public place (where?) At home residence.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md. Date signed: Apr 24 46